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Long-Term Care Hospital Prospective Payment System

LTCH PPS Training Guide

PREPARED BY

EMPIRE MEDICARE SERVICES

This Training Guide was developed by Empire Medicare Services for the Centers for Medicare and Medicaid Services. It has been prepared to assist providers and Medicare fiscal intermediaries (FIs) learn the information they will need to know in order to successfully implement updates to the payment system. This training publication was produced incorporating the best information available at the time of publication. Please refer to the final rule as published in the *Federal Register* for authoritative guidance in the system. This publication should not be considered an authoritative source in making Medicare Program policy determinations.

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Introduction

Using This Training Guide

This training guide has been formatted to highlight key concepts and critical information.

This training guide is divided into four chapters: *LTCH PPS Overview*, *Payment*, *Clinical Issues* and *Billing*. Although each chapter builds upon the previous chapter, each is also comprehensive enough to use for focused training if used in conjunction with the LTCH PPS Overview chapter. This manual has been designed to assist providers in the basic understanding of the Medicare Long-Term Care Hospital Prospective Payment System (LTCH PPS) program and implementation. Providers will receive information on the LTCH PPS components, important changes, and potential additional resources.

This training guide will ease the reader through the LTCH PPS using headings and icons to organize and highlight key concepts.

ICON KEY	
	Interesting Fact
	Key to success
	Make a note of this
	Examples
	Internet Reference
	This may change on a yearly basis

Throughout the manual you will encounter icons that will assist learners in their pursuit of understanding, as well as aid them in quickly finding reference points in the future.

Acronyms List

Commonly used acronyms in the LTCH PPS Final Rule and their corresponding terms are outlined below.

ALOS	Average length of stay
APR-DRGs	All patient-defined, diagnosis-related groups
BBA	Balanced Budget Act of 1997, Public Law 105-33
BBRA	Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Public Law 106-113
BIPA	Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Benefits Improvement and Protection Act of 2000, Public Law 106-554
CCR	Cost-to-charge ratio
CFR	Code of Federal Regulations
CMGs	Case-mix groups
CMI	Case-mix index
CMS	Centers for Medicare & Medicaid Services, formerly HCFA (Health Care Financing Administration)
COLA	Cost of living adjustment
CWF	Common Working File
DRGs	Diagnosis-related groups
DSH	Disproportionate share
FI	Fiscal Intermediary
FY	Federal fiscal year
HCRIS	Hospital Cost Report Information System

HHA	Home health agency
HIPAA	Health Insurance Portability and Accountability Act, Public Law 104-191
ICD-9-CM	International Classification of Diseases 9th Revision
ICF	Intermediate care facility
IME	Indirect medical education
IPPS	Inpatient acute care hospital Prospective Payment System
IRF	Inpatient rehabilitation facility
LTC-DRG	Long-term care diagnosis-related group
LTCH	Long-term care hospital
MCE	Medicare Code Editor
MDC	Major diagnostic category
MDCN	Medicare Data Collection Network
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review file
MSP	Medicare Secondary Payer
OSCAR	Online Survey Certification and Reporting (System)
PCA	Progressive corrective action
PIP	Periodic interim payment
ProPAC	Prospective Payment Assessment Commission
PSC	Patient status code
QIO	Quality Improvement Organization (formerly Peer Review Organization (PRO))
SNF	Skilled nursing facility

TEFRA	Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97-248
UHDDS	Uniform Hospital Discharge Data Set

Definitions

Commonly used terms in the LTCH PPS Final Rule and their corresponding terms have been defined below:

Discharged	A Medicare patient in a long-term care hospital is considered discharged when the patient is formally released or the patient dies in the long-term care facility. For payment purposes, discharge occurs when Medicare days are exhausted.
LTC – DRG	The diagnosis-related group used to classify patient discharges from a long-term care hospital based on clinical characteristics and average resource use, for prospective payment purposes
Hospital-Within-A-Hospital	Part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.
High Cost Outlier Payment	An additional payment beyond the standard Federal prospective payment for cases with unusually high costs
Satellite Provider	A hospital-within-a-hospital type facility that is owned by separate, existing LTCH.
Short-stay Outlier	A case that has a length of stay between one day and up to and including 5/6 of the average length of stay for the LTC-DRG to which the case is grouped.

Chapter 1

LTCH PPS Overview

Highlights of the LTCH PPS

Objective

This section provides participants with background information on long-term care hospital (LTCH) classification and an overview of the prospective payment system for Medicare payment of inpatient hospital services provided by a long-term care hospital. It also introduces terminology and concepts that will facilitate understanding of the detailed discussions in later sections.

Participants will learn about the following information in the course of this chapter:

The statutory basis for the implementation of the Long-term Care Hospital Prospective Payment System.

Which hospitals are and are not impacted by the implementation.

A high-level understanding of the LTCH PPS components and how they interrelate.

Background

LTCHs are certified under Medicare as short-term, acute-care hospitals which have been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under § 1886(d)((1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay of greater than 25 days. The LTCH PPS replaces the reasonable cost-based payment system under which the LTCHs were paid.

Statutory Basis

Section 123 of Public Law 106-113, the Balanced Budget Refinement Act of 1999 (BBRA), as amended by section 307 of Public Law 106-554, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), mandates that a budget neutral, per discharge PPS for LTCHs based on diagnosis-related groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002, to replace the reasonable cost-based payment system mandated by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Affected Medicare Providers

LTCHs are certified under Medicare as short-term acute-care hospitals and, for the purpose of payment, are defined as having an average inpatient length of stay of greater than 25 days.

Provider Number Range

By statute, there are no LTCH units; however, there are satellite and hospital-within-hospital LTCHs that are co-located with acute-care hospitals and other Medicare providers. LTCHs are identified by the last four digits of the Medicare provider number, which range between "*2000*" and "*2299*."

Hospitals Not Affected

The following hospitals are paid under special payment provisions and, therefore, will not be subject to the LTCH prospective payment system rules:

Veterans Administration hospitals

Hospitals that are reimbursed under State cost control systems approved under 42 CFR Part 403

Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90-248 (42 U.S.C. 1395b-1) or section 222(a) of Public Law 92-603 (42 U.S.C. 1395b-1 (note)) (statewide all-payer systems, subject to the rate-of-increase test at section 1814(b) of the Act)

- Two of the four Maryland LTCHs included on CMS's OSCAR database are presently paid in accordance with demonstration projects (i.e., the Maryland "Waiver") and are therefore not subject to payments under the LTCH PPS: Levindale Hebrew Geriatric Center (#212005) and Deaton Hospital and Medical Center (now known as University Specialty Hospital, #212007).

Foreign hospitals, which will continue to have payment made in accordance with the provisions set forth in §413.74 of the regulation. See §412.22(c)

Nonparticipating hospitals

New Average Length of Stay Criteria

LTCH's Average Length of Stay

For cost reporting periods beginning on or after October 1, 2002, the LTCH average length of stay is based on the hospital's Medicare inpatients' total days medically necessary days (**covered and noncovered days**). Previously all days for both Medicare and non-Medicare patients were used to determine the hospital's average length of stay. CMS has changed its methodology for determining the average inpatient length of stay to exclude non-Medicare patients. However, it is not changing the methodology for counting both covered and noncovered Medicare days when calculating whether the LTCH meets the 25-day average length of stay.

CMS has directed FIs to determine whether existing LTCHs qualify for payments under the LTCH PPS according to the revised criteria after October 1, 2002. In addition, CMS has directed FIs to notify LTCHs about whether an LTCH qualifies for payment under the LTCH prospective payment system before the start of the LTCH's next cost reporting period. FIs will continue to monitor compliance with the new requirements.

Related Statutory Citations

CMS changed the methodology for determining the average length of stay for purposes of section 1886(d)(1)(B)(iv)(I) of the Act, but is not changing the methodology for purposes of section 1886(d)(1)(B)(iv)(II) of the Act (Sec. 412.23(e)). For purposes of the latter provision (subclause (II)), CMS is retaining the current methodology (which includes non-Medicare as well as Medicare patients) because it believes that the considerations underlying the change in methodology for subclause (I) are not present under subclause (II).

New Long-Term Care Hospitals

A new LTCH is a hospital that has its first cost reporting period as an LTCH beginning on or after October 1, 2002. It also must not have received payment as an LTCH for discharges occurring prior to October 1, 2002 under present or previous ownership (or both).

Payment Provisions Under LTCH PPS

The BBRA of 1999 as amended by the BIPA of 2000 authorizes the establishment of payment rates under a PPS for LTCHs. The BIPA confers broad authority on the Secretary to determine what payment system adjustments should be included in the LTCH PPS, both on a facility level and on a case level, in order to ensure that payment most accurately reflects cost.

LTCH PPS applies to inpatient hospital services furnished by Medicare-participating entities that have been excluded from the acute care hospital inpatient prospective payment system as LTCHs.

Prior to October 1, 2002, each LTCH was paid on a hospital-specific basis under the TEFRA system. When the PPS is totally phased-in, after the five-year transition period, all payments to LTCHs will be based on a standardized amount per patient discharge, a **Federal payment rate**.

The per discharge Federal rates under the prospective payment system will be based on average LTCH costs in a base year updated for inflation to the first effective period of the system. The prospective payment system will be updated annually as is done with the inpatient, IRF and SNF/Swing bed PPS systems.

Payment under LTCH PPS is dependent on determining the patient classification, that is, the assignment of the case to a particular Long-Term Care Diagnosis Related Group (LTC-DRG), the relative weight of the LTC-DRG and Federal payment rate.

Periodic Interim Payment

LTCHs may elect to be paid using the periodic interim payment (PIP) method described in §413.64(h), and may be eligible to receive accelerated payments as described in §413.64(g).

Patient Classification System

In general, a case will be grouped based on the clinical characteristics of the Medicare beneficiary. These patient classification system groupings are called LTC-DRGs. The LTC-DRGs are based on the existing DRGs used in the IPPS.

Patient discharges will be grouped using ICD-9-CM codes based on the principal diagnosis, up to eight additional diagnoses, up to six procedures performed during the stay, age, sex and the discharge status of the patient. The same GROUPER software developed for the inpatient PPS will be used, but with LTCH-specific relative weights. For fiscal year (FY) 2003, Version 20 hospital inpatient PPS GROUPER will be used.

Relative Weights

Payment weights assigning a specific value representing the relative resource use of each LTC-DRG have been determined by the "hospital-specific relative value method." This methodology normalizes charges within each hospital and then compares them across hospitals. These relative weights will be updated annually using the most recent available claims data.

Payment Rate

Payments to LTCHs under the LTCH PPS will be based on a single standard Federal rate for both the inpatient operating and capital-related costs, but not certain pass-through costs. The FY 2003 LTCH PPS standard Federal rate is $34,956.15. This single standard Federal rate will be updated annually by the excluded hospital with capital market basket index.

Payment Adjustments

The LTCH PPS does not include any of the following "typical" adjustments to the standard Federal rate found in other prospective payment systems: rural location, geographic reclassification, disproportionate share (DSH) or indirect medical education (IME).

The LTCH PPS does include some other typical adjustments to reflect differences in area wages. The standard Federal rate will also be adjusted by a cost-of-living adjustment (**COLA**) for LTCHs located in Alaska and Hawaii.

Additional payments will be also made for high cost outlier cases that exceed the outlier threshold (LTC-DRG payment + fixed-loss amount).

Case-Level Adjustments

Payments to LTCHs are based on the LTC-DRG as well as adjustments specific to the case. Unlike IRF PPS, there are no special payment policies for transfer cases or deaths. Therefore, if a patient in LTCH "A" is discharged and then admitted to LTCH "B," each LTCH will receive a separate LTC-DRG payment based on the number of days the patient is in the respective LTCH.

However, CMS has established payment categories for certain cases that have stays of considerably less time than the average length of stay, known as "short-stay outliers." In addition, there are special payment policies for cases defined as "interrupted stays" and "high cost outliers."

There are also special payment policies for LTCHs that are co-located with other Medicare providers.

Short-Stay Outliers

Short-stay outliers have stays of considerably less than the average length of stay. The patient receives less than the full course of treatment for a specified LTC-DRG and therefore would be paid inappropriately if the hospital were to receive the full LTC-DRG payment. A short-stay outlier is a case that has a length of stay less than or equal to 5/6 of the average length of stay (ALOS) for the LTC-DRG to which the case is grouped. A short-stay outlier will be paid the least of:

120 percent of the cost of the case,

120 percent of the LTC-DRG specific per diem payment, or

The full LTC-DRG payment.

Example

If the ALOS for a particular LTC-DRG is 30 days, then the short-stay outlier policy would apply to any stays that are 25 days or less in length. (5/6 of 30 days is 25 days)

Interrupted Stays

An interrupted stay is a case in which an LTCH patient is discharged and then admitted directly to an inpatient acute care hospital, an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF) or a swing-bed and then returns to the same LTCH within a fixed period of time. The fixed period of time for each provider type is as follows:

Acute care hospital – 9 days or less

Inpatient rehabilitation facility (IRF) – 27 days or less

Skilled nursing facility (SNF) – 45 days or less

Swing-bed hospital – 45 days or less

If the length of stay at the receiving provider is equal to or less than the applicable fixed period of time prior to returning to the LTCH, it is an interrupted stay. An interrupted stay is treated as one discharge for the purposes of payment and only one LTCH PPS payment is made.

Short-stay outliers are also eligible for high cost outlier payments if their costs exceed the outlier threshold.

High Cost Outliers

Additional payments will be made for those cases that are high cost outliers; that is, they have unusually high costs. A case will fall into this category if the estimated cost of the case exceeds the outlier threshold. The outlier threshold is the LTC-DRG payment plus a fixed-loss amount. The fixed-loss amount is determined such that projected outlier payments are equal to eight percent of total LTCH PPS payments. The fixed-loss amount for FY 2003 is $24,450.

High cost outlier cases will be paid 80 percent of costs above the outlier threshold.

Facility-Level Adjustments

Facility-level adjustments are based on individual LTCH characteristics.

Area Wage Adjustment

The LTCH PPS will include an area wage adjustment that will be phased in over five years. The wage adjustment will be made by multiplying the labor-related share of the standard Federal rate by the applicable wage index value. For fiscal year (FY) 2003, the labor-related share of the standard Federal rate is 72.885 percent.

COLA

There is a cost-of-living adjustment (COLA) for LTCHs located in Alaska and Hawaii.

The adjustment is made by multiplying the nonlabor-related portion of the unadjusted standard Federal rate by the applicable COLA factor from OPM based on the county that the LTCH is located (similar to the COLA under the hospital inpatient PPS). For FY 2003, the nonlabor-related share of the standard Federal rate is 27.115 percent.

Other Facility-Level Adjustments

Based on analyses of patient charge data from FYs 2000 and 2001, MedPAR data and cost report data from FY 1998 and 1999 HCRIS data, there was no empirical evidence to support other adjustments. Therefore, there will be no adjustment for DSH, IME, or geographic reclassification.

Co-Located Providers

There is a special payment policy for Medicare providers that have the same location or that are on the same campus as an LTCH. Co-located providers include hospitals within hospitals, satellite facilities, and on-site SNFs/swing beds.

If the rate of discharges and readmissions between the LTCH and a co-located acute hospital exceeds five percent, only one LTC-DRG will be made to the LTCH for all such discharges and readmissions during that cost reporting period. If an LTCH is co-located with other Medicare providers, there is an additional five percent threshold for all such discharges and readmissions to the LTCH.

LTCHs must inform their FIs of co-located facilities and payment reconciliation will occur at the end of the cost report period. LTCHs will be required to notify their FIs about the providers with which they are co-located within 60 days of their first cost reporting period that begins on or after October 1, 2002. A change in co-located status must also be reported to the FIs within 60 days of such event.

Budget Neutrality and Offset to Payments

Total payments under LTCH PPS must equal the amount that would have been paid if the PPS had not been implemented. A reduction factor applies to all Medicare LTCH payments during the transition to the LTCH PPS to account for several factors. This transition to the "full" Federal payment rate will be described in additional detail in *Chapter 2–Payment*.

Implementation Phase-in

The PPS for LTCHs will be phased in over five years from cost-based reimbursement to Federal prospective payment. During this period, payment is based on an increasing percentage of the LTCH payment and a decreasing percentage of its cost-based reimbursement rate for each discharge. LTCHs may exercise a one-time, irrevocable opportunity to elect payment based on 100 percent of the Federal rate rather than transition from cost-based reimbursement to prospective payment.

Beneficiary Liability

Beneficiary liability will operate the same as under the previous cost-based, TEFRA payment system. Therefore, even if Medicare payments are below the cost of care for a patient, the patient cannot be billed for the difference in any case where a full LTC-DRG payment is made.

Generally, beneficiaries may be charged only for deductibles, coinsurance and noncovered services (telephone and television for example) for days where there is Medicare coverage. Beneficiaries (or their Medigap insurance) are responsible for all noncovered days as described below:

Once a stay triggers a full LTC-DRG (i.e., it exceeds the short stay outlier threshold), Medicare will pay for the entire stay up to the high cost outlier threshold regardless of patient coverage. However, Medicare will only pay for covered days for lengths of stays that are within the short stay outlier policy.

When an LTCH receives less than the full LTC-DRG payment, as in the case of the short-stay outlier, beneficiaries may also be charged for items and services provided during the stay that were not the basis for the short-stay payment.

To reiterate, **beneficiaries may not be charged for the differences** between the hospital's cost of providing covered care and the Medicare LTCH prospective payment amount for the full LTC-DRG.

The policy for use of lifetime reserve days (LTR) will be discussed in the Payment and in the Billing chapters.

Billing Changes

LTCHs will continue to use most of the same billing principles and practices. However, billing under LTCH PPS introduces the new concept of billing "one claim for an entire" stay. Within this concept, providers will learn that when late charges will be submitted through an adjustment, split billing has been eliminated, claims must include any incurred "interrupted stay" and that only non-PIP providers may submit interim bills. Several claim examples reflecting possible billing situations will be reviewed in *Chapter 4–Billing*.

Processing Between October 1, 2002 and January 1, 2003:

Currently, there are edits in place that prohibit the submission of claims that span an LTCH's fiscal year start date. These edits require the hospital to split the bill over the cost report begin date. Until LTCH PPS systems changes are in place, LTCHs must continue to split their bills if there are patients in the LTCH when the LTCH transitions over to PPS. Once the changes are implemented, pre-PPS bills must be cancelled and the entire stay should be re-billed under PPS.

Correct Coding

Correct ICD-9-CM diagnosis and procedure coding by the LTCH is very important as these codes play a role, along with other factors, in the way in which a Medicare claim is paid. In *Chapter 3–Clinical Issues*, we will review this issue as well as provide information on Medicare requirements and coverage criteria for inpatient hospital services related to LTCH PPS.

Processing Bills Between October 1, 2002 and the Implementation Date

All applicable LTCH PPS coding must be used by LTCH providers with cost reporting periods beginning on or after October 1, 2002. However, CMS will not have the standard computer systems changes necessary to accommodate claims processing and payment under the LTCH PPS in place before January 1, 2003. Claims submitted prior to implementation will be processed under the reasonable cost-based payment methodology. On or after January 1, 2003, those processed claims will be mass-adjusted by the FI to reflect the PPS payment methodology.

Beginning October 16, 2002, all LTCHs will also be required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD-9-CM coding.

Medical Review

As established in the Medicare Program Integrity Manual (Rev. 24, 04-05-02), FIs are authorized to conduct medical review of LTCH PPS claims notwithstanding the agreements required between LTCHs and Quality Improvement Organizations (QIO), under the LTCH PPS, for admission and quality review. All FIs are required to conduct data analysis to proactively identify aberrant providers. If data findings indicated LTCH aberrancies, the FI will implement the appropriate progressive corrective actions (PCA).

For payment purposes, Medicare will not cover any patient stay, even if the patient has remaining Medicare days, if that stay has been determined not to have met the medical necessity, reasonableness, and appropriateness standards of the medical review procedure established under the final rule. In such case, the days of a stay failing medical review will be excluded from the qualification computation for the LTCH's cost reporting period.